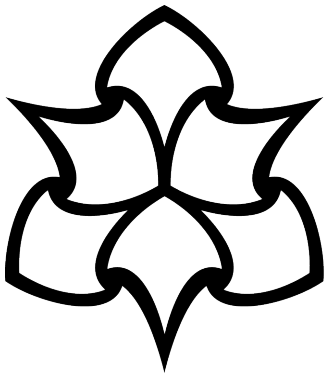

Children and Domestic Homicide

Abstract

In England and Wales, Domestic Homicide Reviews (DHRs) are completed following domestic homicides. They provide multi-agency accounts of families living with domestic violence and abuse (DVA) and their interactions with services. This study addressed children's involvement in domestic homicide. We analysed all DHRs where there were children under 18 among those published 2011-2016. This yielded a sub-sample of 55 DHRs from a total of 142 reports. The extent of children's exposure to homicide varied with some directly witnessing the homicide, viewing the aftermath or calling for help. DHRs provided limited information on children's needs or their future care and children were only rarely involved in the review process itself. Nearly a third of reports identified that children had previous experience of DVA and contact emerged as a means of sustaining control and intimidation. There was evidence of blinkered vision among professionals who missed indicators of DVA and failed to engage with perpetrators or listen to children. Practitioners need training and assessment tools that direct their attention onto children and knowledge of resources that enables identification of need and appropriate referrals. Law and practice should address children's involvement in the DHR process and the risks embedded in child contact.

Key words: Child safeguarding, Domestic Homicide Reviews, Domestic violence and abuse, Homicide.

Since 2011, Community Safety Partnerships in England and Wales have been required to undertake a multi-agency review following a domestic homicide. These are defined as deaths of a person aged 16 or over that has, or appears to have, resulted from violence, abuse or neglect by a relative or by someone with whom s/he was in an intimate relationship, or by a member of the same household (Home Office, 2016a). In the UK, the report produced is known as a Domestic Homicide Review (DHR). Nearly 150 of these reports were published between 2011 and 2016 and DHRs offer a valuable source of information on the dynamics and impact of domestic violence and abuse (DVA) and on the challenges of interagency collaboration in respect of these cases. In common with serious case reviews on child deaths (Brandon et al, 2012; Sidebotham et al, 2016), DHRs can draw public and political attention to violence and abuse within families and they utilise hindsight to make recommendations about how such deaths can be prevented in future. The narrative accounts produced illuminate the experiences of those involved in extreme and fatal events and their interactions with a range of services.

Domestic homicides are usually the culmination of a long-term history of DVA (Kaplan et al, 2001; Sharps-Jeff and Kelly, 2016). DVA is a gendered crime with the most sustained and serious forms of abuse with severe impact being perpetrated by men (Ansara and Hindin, 2009; Hester, 2013) and women constitute the vast majority of domestic homicide victims (ONS, 2016). It can involve both adult and child victims and, in this paper, we focus on children's involvement in domestic homicide. We consider both their positioning in and contribution to DHRs as well as examining what can be learnt from DHRs about children's needs and the service response to children living with DVA . This analysis of DHRs is the largest-scale undertaken to date in England and Wales and it provides some useful indicators for practice, policy and research in this field.

A review by Alisic et al (2015) reveals the extent to which previous studies of children involved in domestic homicide have relied on case studies drawn from clinical records. Harris Hendrik's et al's

(1993) early research remains one of the most substantial of these studies: they utilised the clinical assessments of 95 children whose father had killed their mother. They highlighted PTSD as a high risk, especially for those children who had witnessed the homicide, and recommended early intervention from mental health services. Kaplan et al (2001) followed up about two-thirds of the children from this early study by surveying the original referrers and concluded that those who had received treatment had fewer problems. Children who were placed with the perpetrator's family did worse than other children on a number of ratings and were more likely to return to live with the perpetrator following his release from prison. Hardesty et al (2007) interviewed caregivers of 10 children who had lost their mother following domestic homicide and found that children experienced a range of physical and mental health problems as well as behavioural and academic problems. Caregivers often struggled to manage both these needs and their own health. Such studies risk being confined to the perspective of one particular agency or focus on those children who have received an intervention. The challenges of collecting comprehensive data on a sizeable sample of these homicides in the absence of DHRs, are illustrated by Alisic et al's (2017) recent Dutch study which synthesised data from eight different sources, including the databases of statutory agencies and press reports, to elicit demographic, family and homicide characteristics for 137 cases of intimate partner homicide over a 10 year period. They argued that post-homicide care of child survivors should address: histories of maltreatment and experience of DVA; exposure to the homicide, traumatic bereavement, cultural differences and disruption of daily life.

As the practice of conducting multi-disciplinary reviews following a domestic homicide has developed internationally (Bugeja et al., 2015), analyses of these reviews that explore children's involvement have emerged. In the US and Canada, Domestic Violence Death Review Committees (DVDRCs) review deaths that occur in the context of DVA. Jaffe and Juodis' (2006) overview of 14 DVDRC reports found that children were affected by the homicides in between 35 and 65 per cent of cases and identified a range of ways in which children were victimised. A further analysis by Jaffe et

al (2012) examined 1,006 incidents of domestic homicide from the US and Canada and found that a total of 95 children were killed.

UK analyses of DHRs to date have tended to focus on interagency communication and collaboration prior to the homicide. Two rapid reviews of DHRs in 2013 and in 2016 identified missed opportunities for safeguarding children (Home Office, 2013, 2016b). Neville and Sanders-McDonagh's (2014) analysis of 13 DHRs from the West Midlands recommended improved collaboration between children's and adults' services; this review noted that a number of reviews highlighted women's fear of losing children to the care system as a barrier to seeking help for DVA. Child safeguarding issues were identified in over a third of the 29 DHRs analysed by Sharps-Jeff and Kelly (2016). They found that, for practitioners, 'holding both women and children, and their relationship, in view is the challenge' (Sharps-Jeff and Kelly, 2016, p 72).

Analysis of DHR reports offers insight into family history and dynamics and builds a picture of professional activity in these families. The harm inflicted on child survivors of domestic homicide is likely to be long-term and severe (Jaffe and Juodis, 2006; Alisic et al, 2017). Alisic et al's (2015) review identifies a range of psychological and physical harm experienced by children who as the authors note, have not only lost their primary caregiver but also the person who might have assisted them in adjusting to that loss. In some cases, children also lose their lives (Jaffe et al 2012). This paper uses the accounts provided by DHRs as a means of examining children's experiences prior to, during and following domestic homicides in addition to identifying key themes relevant for practitioners responding to DVA. We approach DHRs as constructed, partial accounts and we consider the extent of children's and young people's involvement in the review process.

Methodology

In June 2016, we identified and collected 142 DHRs available on local Community Safety Partnership websites in England and Wales. This allowed us to include all those DHRs still accessible online that had been published since July 2011. It is possible that some reports may have been removed from the relevant website or were never published online due to concerns about sensitivity or legal constraints. Bridger et al (2017) found delays in both commissioning and publication of DHRs: nearly 48% had not yet been published two years after the cut-off date for their sample. Most DHRs are available in both summary and full versions and both reports were collected where available. DHRs are publicly available documents that have already been anonymised and, since the study was desk based and did not involve collecting any new data, ethical approval was not required. Fifty-five (39%) of the reports involved families that included children under 18 and the findings reported here are drawn from this sub-sample.

A data extraction form was used to collect information from the DHRs. Quantitative data was captured on over 100 variables and fed into SPSS. Data collected included: demographics, family structure, the victim's and perpetrator's mental and physical health, the nature of children's involvement in the homicide, service involvement pre-homicide and children's post-homicide living arrangements. The three authors shared the analysis of the 55 reports with regular meetings and cross-checking to ensure consistency. Close reading captured narrative extracts utilising themes identified from the literature as well as those arising from the reports themselves (Charmaz, 2016). This approach provided more in-depth information on some of these variables as well as on additional factors such as living and contact arrangements, history of abuse or harm of children and DHR recommendations in respect of children. Data was cleaned and re-coded where appropriate. Descriptive analysis of the quantitative data was carried out using SPSS to generate frequencies and proportions.

Results

Below we provide demographic details of 125 children involved in the 55 DHRs and report the nature of their involvement in the homicide together with information about its impact on children. We then move to consider themes relating to family history, in particular children's experiences of harm and abuse and the issue of contact. We consider service involvement, focusing on identified deficiencies in communication, recording, risk assessment and service delivery as well as failures of vision or perspective. Finally, we report on how children were involved in and positioned by the DHR process.

Demographic Information

DHRs do not always provide demographic information on children: current guidance (Home Office 2016a) recommends that a child's gender should not be identified. This is in part an attempt to anonymise survivors and protect them from stigma or intrusive media coverage but it may also reflect a lack of attention to children in these families. From the information available, the 125 children identified in these 55 DHRs ranged in age from 11 months to 17 years. Of the 59 for whom gender was reported, 33 (56%) were male and 26 (44%) were female. Ethnicity appeared most likely to be reported by DHRs when it was other than White British (although recent guidance (Home Office 2016a) states that the ethnicity of the victim and perpetrator should always be reported), but the scantiness of information in this respect makes it inappropriate to report figures.

Many of these families had complex structures and, while 52 children were the children of both the homicide victim and the perpetrator, 36 were the victims' children from previous relationships and 37 were the perpetrators' children from previous relationships.

The vast majority (93%) of the 55 DHRs involved a male perpetrator. In 45 DHRs (82%), the male perpetrator was the victim's current or former partner, in five cases, parents were killed by their adult sons or son-in law; in four cases, the victim was male and the perpetrator female; in one, both were male.

Children's Involvement in Domestic Homicide

The exact nature of children's involvement in these violent events was not always easily discernible: the DHRs did not consistently report the extent of children's exposure to a homicide and in some cases children's whereabouts were uncertain or the children were too young for the review panel to ascertain what they had seen. Table 1 shows the extent of children's direct exposure to the homicide.

Insert Table 1

Two DHRs reported that children were killed alongside their mothers: both cases involved fires started by the mother's former partner. In three reports, children were directly injured in the course of the homicide. Children were identified as present in the house at the time of the homicide in about a third of the reports analysed; in six DHRs, children were described as directly witnessing the homicide and, in another five, they saw their mother's body immediately post death:

> *On the day of the homicide: 'Child B returned home with a friend at that point and saw Adult A assaulting Adult B…Police report that Child B tried to intervene'* (DHR025 overview report, p16)

One child was on his/her own with their mother's body for over 24 hours (DHR012). Another assisted in lifting the victim's body into the car (DHR076) and in another case, two young children were driven around by the perpetrator in a car with the victim's body in the boot (DHR003).

In five cases, children were described as calling for help:

> *The eldest daughter (aged 15) was physically prevented by the perpetrator from going to her mother's aid…. [she] told the perpetrator she needed to get some provisions for the baby and he took her and the other children to the shops. She managed to engineer a situation where she went into one of the shops with one of the children, leaving the perpetrator outside with the others. She spoke to a shop worker who contacted the police. The perpetrator was later found with the other children.* (DHR120)

Other children were described as contacting neighbours or the police for help.

Impact of Homicide on Children

The DHRs studied rarely addressed the impact of the homicide on children. Where such insights were found, they indicated a need for ongoing support for both children and their carers:

> '*Christopher's mother has also shared the following information about the massive impact that domestic abuse has had on Peter and Elaine, both prior to and after the homicide;-*
>
> • *Both have a mistrust of family and professionals and have a fear of being taken into care again.*
>
> • *Both have displayed violent behaviour referring to the way their parents acted as being acceptable.*
>
> • *Peter has serious behavioural difficulties.'* (DHR050, Overview Report, p58)

Eleven DHRs mentioned that children were receiving support post-homicide and this was provided or accessed via schools, children's social care or Victim Support Services. Three reports identified a need for trauma-focused support and one DHR flagged up the need for longer-term support:

'the DHR Chair is aware that although some support has been available to them, more specialised and longer term help is required. It is vital to the wellbeing of Billy's children and stepchildren that specialist support is available to them...' (DHR055, Overview Report, p32)

The most immediate impact for most of the children (some were already living with a previous partner or were looked after elsewhere) was that their living arrangements changed following their mother's death. Children's future living arrangements were not always specified but where a parent who was not the perpetrator survived, children usually went to live with them; in four DHRs, children were described as in local authority/foster care; two were living with older siblings; five with grandparents; four with other family members.

As Alisic et al (2017) found, families were not always adequately supported to undertake this role:

'*DC's mother and her husband took over the care of the children following their mother's death and their father's imprisonment. Immediately after the event there was no financial support available to help with clothing and bedding for the children. As a retired couple, their income was very limited and DC's father returned to part-time work to help provide for the children's needs. DC's mother also had to stop work early to look after the children. The family feel that their need for financial support was not adequately recognised and that they have struggled to manage this burden on top of the tragic loss…'* (DHR054, Executive Summary, p13)

Children's Previous Experience of Abuse and DVA

For many of the children, their mother's death was the culmination of a long history of harm that often involved DVA. DHRs do not systematically report children's previous experiences of harm or abuse but 16 DHRs (29%) did describe children in the family being exposed to DVA by the victim's current and/or previous partners. Two reports noted that children had been previously injured in DVA incidents. Physical abuse or assault of children was mentioned in 11 DHRs, threats of violence

towards children from the perpetrator appeared in four reports and four mentioned neglect. Two DHRs described the perpetrator locking children up.

These histories were not always known to services prior to the homicide: in some cases, children's social care had a long history of involvement; in others, initial disclosures or reports appeared not to have been taken any further:

> *'…there were allegations of H1 [perpetrator] threatening himself and both V1 [victim] and C1 [child] with knives, comments V1 made about 'he hurts us' and V1 and C1 having to flee from the household in fear for their lives. It appears neither V1 nor C1 was ever questioned in any depth about the impact H1's behaviour was having on their lives.*' (DHR 132, Overview p57-58)

Contact

In families that have separated, child contact can provide a context in which the abuse of women and children is perpetuated (Stanley et al,, 2011; Radford and Hester, 2015). Contact arrangements, both formal and informal, surfaced as a theme in a third of DHRs. In most of these reports, the issue of contact was mentioned but not explored in depth. However, three reports specifically identified child contact as a means by which coercion or control was sustained:

> '*Some aspects of the father's attitudes and behaviour (e.g. asking the girls if they wanted to go to his house and who loved them more; requesting to take the girls outside of the [contact] centre contrary to the court order) may have been evidence of a manipulative personality..' (DHR042, Overview Report, p30-31).*

In a further four cases, contact was intertwined with threats of abduction:

> **'**The victim…facilitated contact. She told her solicitor that the perpetrator *"always told me that if I ever called the police, or the authorities, then he would take the children and I would never see them again. I believed his threats."'* (DHR060, p 5, exec summary)

An additional two DHRs included the information that children had been scared of the perpetrator and unwilling for contact to happen. Three reviews found failures to identify the risks posed by contact:

> *'…there was evidence from both parties that he still was having contact with the children. The risks involved in this never seemed to be considered and the lack of a chronology on the records meant there was no real overview of the risks.'* (DHR041, Overview Report, p 27).

This DHR highlighted practitioners' willingness to believe that separation could be equated with safety:

> *'…some of the agencies and individuals were of the view that because they had separated then the risk to Cydney [pseudonym] was reduced. When in fact separation, especially in cases involving child contact arrangements coupled with the distance between them may have actually increased the risk.*' (DHR053, Overview Report, 10.8)

Service Involvement

Which Services were Involved?

Since the 55 DHRs were selected on the basis that there were children in the family, children's welfare, education and health services were the agencies most likely to be involved.

Table 2 shows that 30 DHRs (55%) provided evidence of family centre involvement; 28 families (51%) had previous involvement from children's social care; 27 (49%) families from a health visitor or midwife and 20 (36%) had had school involvement. However, only four DHRs mentioned child protection plans.

Insert table 2 – Service involvement

Communication, Recording, Risk Assessment and Service Delivery

In common with serious case reviews (Sidebotham et al 2016), lapses in interagency communication and collaboration in respect of children and their needs characterise a number of DHRs. Such accounts identify established patterns of 'silo' working as well as failures to share information at the right time:

> *'…it appears that the ordeal suffered by the child who discovered the body of her mother could have been prevented… Probation and …Children's Social Care had a duty to communicate with each other as the release date for Adult B drew closer…Had they done so…it is reasonable to assume that they would not have agreed to the child being allowed to stay over with Adult A over the weekend immediately following Adult B's release from prison.' (DHR012, Overview Report, p35)*

DHR reports often highlight poor record keeping as the absence of relevant records can be a substantial impediment to the review process itself. The Home Office (2016b) review of DHRs singled out poor record keeping as the most common theme in DHRs sampled with GP records being cited as those most frequently found wanting. Record keeping problems included missing information, decisions recorded but lacking a rationale and omission of some family members:

> *Katie [pseudonym] attended A&E. It was noted she was pregnant with twins. No mention is made in the notes that she also had a young son. …There is nothing to indicate that the midwife was informed about the visit* (DHR113, Overview Report 2.3.10.4)

The DHRs identified a variety of shortcomings in relation to risk assessment. In some reports, this entailed a failure to refer a victim to the local MARAC (Multi-Agency Risk Assessment Conference). As Table 1 shows, only seven victims in the 55 DHRs had been referred to a MARAC. Elsewhere, risks were misinterpreted or their severity was not appreciated. In some instances, practitioners overlooked connections between different forms of risk and one report (DHR114) highlighted failures to make the link between the perpetrator's sexual assaults on adults and children's safety.

DHRs also identified missed opportunities to provide services following identification of need. In some cases, this involved failing to refer families to children's social care. In others, reviews identified a lack of support for children known to be experiencing DVA:

> *'This was poor practice both in terms of failure to get help for Peter who had witnessed a traumatic incident involving a knife and to consider the continued exposure to domestic abuse that he had endured between his father and mother and now in this other relationship.'* (DHR050, Overview Report, p15)

Blinkered Vision

Many of the criticisms concerned professional viewpoints that were restricted to a single area of need or to the needs of only one family member. In some DHRs, this blinkered vision led practitioners to miss indicators of DVA. This sometimes occurred because the family's needs were constructed around one particular issue such as the perpetrator's mental health needs or the victim's substance misuse or parenting:

> *'Adult A's status as a victim of domestic violence was obscured by a number of issues such as the culture of violence which surrounded her substance misuse which was too readily accepted by some of the staff who worked with her. Adult D says that agencies saw her sister as a "smack head" and did not recognise her as a victim of domestic violence'.* (DHR012, Overview Report, p44)

Both this extract and that cited below indicate that constructions of service users as 'compliant/deserving and uncompliant/undeserving' may also have influenced professional judgments:

> *'…some professionals believed the victim to be unreliable and "not truthful" about the relationship between her and the perpetrator and whether they were together or not. The*

repeated pregnancies were interpreted as a sign of a relationship rather than explored…as possible sexual violence and control.' (DHR002, Executive Summary, p11)

Five DHRs highlighted the invisibility of the perpetrator to practitioners and noted how a lack of professional engagement with him resulted in the victim being required to take responsibility for the children's safety:

'…there is evidence of… [Children's Social Care] holding Adult H [the victim] responsible for safeguarding Child F … Adult G was not challenged or held accountable for his behaviour. No attempt was made by Children's Social Care to engage with Adult G or create an opportunity to talk to him about how he could change his behaviour and understand the impact of his actions on his child.' (DHR031, Executive Summary, p33)

Failure to hear children's voices

A failure to listen to children was emphasised in six DHRs:

'…her son's experience of living with domestic abuse and the fear of its recurrence was not given sufficient weight. He was never spoken to by the police or by the school despite witnessing a serious attack on his mother and his mother's expressed fear to the school that he was at risk.' (DHR134 Overview Report p46)

Some DHRs highlighted the need for adult workers to elicit and respond to children's accounts in their recommendations.

Children's Involvement in the DHR process

Despite this emphasis on the importance of hearing children's voices, children appeared to be only rarely invited to contribute to the DHR process. Where reports gave reasons for this, it was because

children were judged too young, because there were concerns about compounding trauma, or because of anxieties about protecting anonymity.

In a small number of cases (3), children were invited to contribute to the review process and declined and in a few cases, family members or professionals provided comments on behalf of children.

In three reports, older children chose to provide comments to the review and did so in a way that was supported. One young person whose brother killed their mother articulated strong criticism of mental health services and their failure to take account of her perspective:

> '*R told the Panel Chair that she had felt ignored and unsupported by services dealing with her brother in the months before her mother's death… in particular she highlighted that no-one talked to her directly about her experiences and feelings at the time or appeared to consider that they mattered in coming to decisions about her brother*.' (DHR119, Overview Report, p5)

Other young people who contributed their views emphasised the impact of DVA on their lives. One young person described the way that her father treated her mother as 'torture'. In this case (DHR142), it was arranged for the DHR report to be attached to the children's social care record so that it could be accessed by them at a later date.

Discussion

DHRs have their limitations as accounts of family dynamics and of professional practice. They are partial documents that often reflect the particular interests or professional background of their author; they are compiled with the benefit of hindsight and there are inconsistencies in the quality,

nature and quantity of data they provide. This lack of a common format makes for challenges in interpreting and quantifying the information captured: it was often hard to determine whether information was missing because it was not a feature of the case, because it was not elicited or recorded by practitioners or because the DHR process did not collect it. Nevertheless, DHRs are a means of synthesising information from a large number of agencies that would require very considerable resource to collect otherwise and the integration of multiple sources of information offers a more holistic picture of both families and professional intervention than research often achieves. In common with other homicide inquiries, DHRs' focus on deaths has meant that policy has been driven by negative rather than positive practice and, despite counter-efforts within the fields of both policy and practice (Munro 2011; Fish et al 2008), professionals have consequently been blamed for failures that are systemic rather than individual. However, DHRs have succeeded in bringing the issue of DVA and its potentially fatal outcomes to public and political attention and in forefronting the gendered nature of intimate homicides.

This analysis has highlighted the way in which domestic homicides impact on children's lives. In a third of the reports analysed, children were in the house at the time of the homicide and these children may be particularly at risk of experiencing PTSD alongside other adverse effects (Harris Hendrik et al, 1993). Children's needs for support and intervention are likely to be ongoing and may need to be revisited over time (Alisic et al 2017). It would be helpful for DHRs to record more consistently what support is offered and taken up in the short-term and this approach might ensure that more children are provided with appropriate support. Most DHRs in our sample gave scant consideration to children's needs for current or future support. Further research could usefully explore what types of intervention are most valuable for children who survive a domestic homicide and how, when and where these interventions could be easily accessed by children, young people and their carers.

The DHR provides an in-depth account of a homicide that is likely to survive over time and these accounts need to be easily available to inform future interventions with children and carers. They could also be conceptualised as a source of information that might be used to enhance children's understanding of the homicide in the present or future. Attaching the homicide report to the children's social care case files offers a model of good practice that could be replicated.

Children's involvement in the review process also requires fuller consideration (Sharps-Jeff and Kelly, 2016). The Home Office guidance on DHRs notes that 'Children should also be given specialist help and an opportunity to contribute as they may have important information to offer' (Home Office 2016a, p 17). Our analysis suggests that children are not consistently offered opportunities for participation. Morris et al's (2015) study of family participation in serious case reviews identified a number of drivers for family inclusion in reviews but concluded that the 'rules of engagement' for families' participation in case reviews needed revisiting. DHR chairs may require more guidance than is currently provided as to how to best inform and include children and young people. Concerns to protect anonymity appear to be a substantial barrier to both involving children and to providing accounts that fully report their involvement in a homicide. Whilst it is appropriate to protect children from exposure to adverse publicity and stigma, limiting the information regarding children can remove them from the account and constrains understanding of both the role they may have played in the events preceding the homicide and their experience of its impact. Practice in respect of anonymising survivors varied across the DHRs analysed and further guidance may also be required in this respect.

DHRs also provide valuable learning on families' experience of DVA and the service response. Nearly a third of children were recorded as having experienced DVA on an ongoing basis and, given the failures of some of the services involved to recognise and record DVA, it is likely that this figure was higher in reality. Contact emerged as a key means through which control and intimidation of

mothers and children were sustained following separation and the predisposition of both the legal and welfare systems towards supporting contact need to be more readily challenged for families with ongoing histories of DVA (Radford and Hester, 2015). DHRs also highlight practitioner failures to identify the risks inherent in contact: there is now considerable evidence showing that separation cannot be equated with safety and should not be established as the primary goal of intervention for all families living with DVA (Stanley et al, , 2011; Stanley and Humphreys , 2014).

Children themselves, when asked, can express clear views about the risks and value of contact (Holt, 2015, Eriksson, 2009). It is concerning to discover that their views were not always elicited even when children were teenagers. In some cases, the professionals who failed to do so were children's social workers and teachers and, for these practitioners, a failure to talk directly to children about their experience of DVA may reflect a lack of knowledge concerning DVA or a lingering sense that DVA should remain an adult issue. Maintaining a focus on children in a family can be a particular challenge for practitioners in adult mental health services or substance misuse services (both of whom had involvement with these families) whose primary focus is the adult patient and there have been some initiatives designed to promote mental health practitioners' awareness of and responsiveness to children in families (SCIE 2012; Davidson et al 2012). Practitioners in adult services need assessment tools which direct their attention to children and they require knowledge of relevant resources to offer children if their engagement reveals a level of need beyond their own competence. In the absence of the latter, these professionals will have little reason to talk to children as doing so will only confirm their own shortcomings and inability to provide relevant support. The analysis revealed that, although a wide range services were engaged with these families, relatively few received support from DVA services, indicating a lack of collaboration with the specialist DVA sector.

Professional failures to identify DVA in families prompt similar suggestions as to how knowledge, skills and confidence in relation to DVA can be improved. Whilst children are nearly always construed as deserving of a service, there is a suggestion in some DHRs that practitioners' assessments in respect of adult victims who stayed with abusive partners or misused drugs or alcohol were restricted or blinkered. Whilst what has been described as 'early evidence or confirmation bias' (Munro 1999; Broadhurst et al 2010) may play a role here, the findings of this study suggest that some practitioners' judgments were clouded by an impatience with perceived lack of change or by judgmental attitudes. In such cases, good quality supervision that challenges assumptions and decisions might make a difference.

DVA perpetrators were another group that sometimes slipped out of the professional arc of vision, leaving mothers with responsibility for protecting children from violence that was beyond their control. There is a growing body of interventions that aim to challenge the exclusion of men from social work interventions with families (Maxwell et al, 2012; Stanley and Humphreys, 2017) and the overview of the findings from Government's Children's Social Care Innovations Programme (Sebba et al 2017) concluded that whole family work that involved fathers appeared successful in reducing DVA. However, the skills and confidence of the children's social care workforce are currently underdeveloped in respect of work with fathers (Baynes and Holland, 2010; Stanley and Humphreys, 2017) and, as noted above, practitioners are unlikely to identify risks where they feel they lack the skills or resources to manage them.

DVA is a gendered phenomenon distinguished by the presence of adult and child victims and this requires children's social care practitioners in particular to be alert to the risks of assigning mothers sole responsibility for children's safety. Making demands on already vulnerable women, such as insisting on separation, will only increase their vulnerability to harm and reduce the flow of information between families and professionals. Engaging more fully with DVA perpetrators and

with the services that work with them such as prisons, the probation service, substance misuse and mental health services, as well as specialist perpetrator programmes, may serve to relieve pressures on mothers and locate responsibility for abusive behaviour more appropriately.

Conclusion

DVA in families is a testing issue for professionals from all settings because it requires practitioners to attend to all family members, to consider what is not disclosed as well as what is disclosed, who is living outside the family home as well as within it and to recognise that safety for one family member may not guarantee safety for another. Blinkered vision leads to restricted information flow between services and results in limited information to inform risk assessment. A number of training and co-location initiatives are emerging (Blacklock and Phillips, 2015; Szilassy et al, 2017; Oram et al, 2016; Sebba et al, 2017) that aim to build knowledge and confidence in relation to DVA as well as increasing practitioners' access to specialist DVA expertise and services. However, most of these initiatives are currently in pilot form only.

The multi-agency perspective of the DHR is helpful in illuminating relationships between different family members' needs and across service divides. However, the 'omniscient' viewpoint of inquiry reports needs to be balanced by the accounts of those intimately involved in the events narrated (Stanley and Manthorpe, 2004) and the DHR angle of vision requires widening to include children who may be key informants and actors in the events described. Moreover, the DHR's capacity to make recommendations for future care of survivors and to enshrine an authoritative narrative of a homicide offers an opportunity to contribute to the recovery of children whose lives will be shaped by the events reported. Government in England and Wales is planning to introduce a Domestic Abuse Commissioner who would have responsibility for quality assurance of DHRs and the consultation on a new domestic abuse law aims to ensure that the learning that DHRs offer is

utilised to improve the service response to DVA (HM Government 2018). The same consultation emphasises the importance of responding to the needs of children living with DVA, including addressing their contact with perpetrators). This analysis of DHRs has revealed much about the continuing invisibility of children living with DVA, which persists even in relation to violent events that will shape their futures. Making children's accounts and experiences more central to DHR narratives could strengthen both policy and practice in this field.

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